CASES

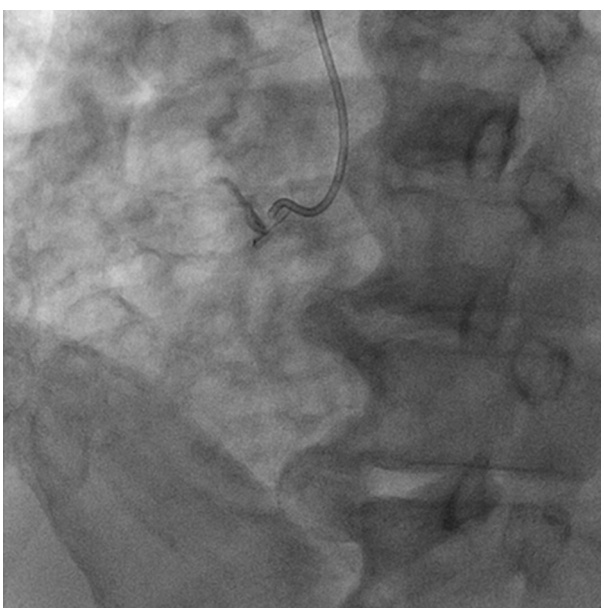
Case Summary:
We crossed the lesion with Sion Blue wire and took IVUS image. The IVUS showed narrowing of stent luminal diameter with intimal hyperplasia. There also might be mural thrombus with suggestion of very late stent thrombosis. We directory implanted a PROMUS Element stent (3.5*16mm). Immediate after stent implantation, the patient fell into hemodynamical collapse and cardiopulmonary arrest. Although the prompt cardiopulmonary resuscitation was performed, spontaneous circulation could not be returned. The TTE showed massive pericardial effusion compatible with cardiac free wall rupture.
Late reperfusion is thought to be a risk of cardiac rupture. The Macroscopic findings of autopsy detected two ruptured point in apical anterior wall. We will report with macro and microscopic findings including coronary artery.

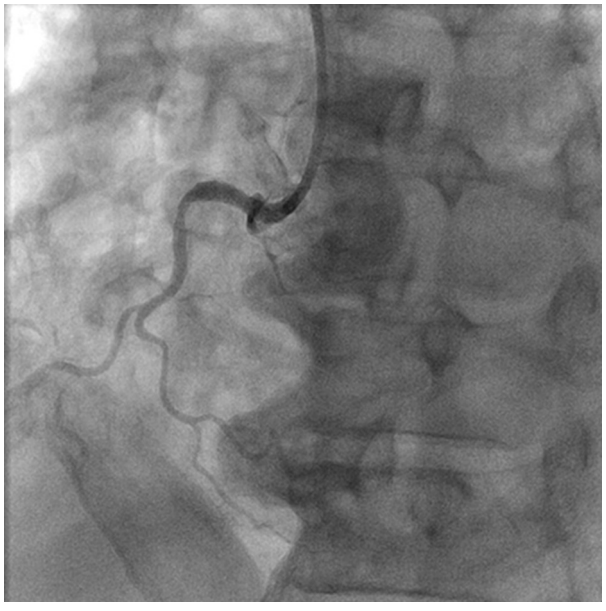
TCTAP C-006

Isolated Right Ventricular Myocardial Infarction Misdiagnosed as Anteroseptal Myocardial Infarction on ECG

Junji Iwaska
Kansai Medical University, Japan

[Clinical Information]
Patient initials or identifier number:
TT
Relevant clinical history and physical exam:
Typical clinical symptoms (chest pain and cold sweat)
no significant sign of heart failure (edema, dyspnea and dullness)
Relevant test results prior to catheterization:
ECG findings: AF rhythm, ST elevation in V1-3Labolatory findings: significant elevation of cardiac enzymes (troponin I, CK and CK-MB)
Relevant catheterization findings:
Total occlusion of RCA segment #1
no significant lesion found in LCA
[Interventional Management]
Procedural step:
Emergent CAG was performed as right radial approach with 5F JL4 and AL1 catheter. CAG revealed a proximal occlusion of the right coronary artery and a patent dominant left coronary artery.
Ad-hoc PCI was performed after CAG with 6F system; 6F Launcher ECR3.5SH guiding catheter and ASAHI Sion guide wire.
After thrombectomy with 6F THROMBUSTER, PCI of RCA was performed.
Pre-dilation: NC TRECK 3.75x15mm
Stent: Integrity 4.0x26mm 10atm
Post-dilation: Integrity balloon 10atm x1, 13atm x1





Case Summary:
Right ventricular MI usually occurs by an acute stenosis of the non-dominant proximal RCA branch that does not receive collateral flow.
This case report demonstrates the potential hazards in distinguishing right ventricular infarction from anteroseptal infarction by electrocardiogram only.

TCTAP C-007

Optical Coherence Tomography in the Case of Myocardial Infarction with Spontaneous Coronary Artery Dissection

Ryota Kakizaki
Kitasato University Medical Center, Japan

[Clinical Information]
Patient initials or identifier number:
0331778, M.K.
Relevant clinical history and physical exam:
A 74 years old male presented to our hospital because of anterior chest pain. Physical examination was normal.
Relevant test results prior to catheterization:
Testing showed an elevated cardiac troponin I (cTnI) at 4.47 ng/mL, creatine kinase (CK) at 298 IU/L (CK-MB 48 IU/mL). Electrocardiogram showed ST depression in leads V2-4 and Q wave in lead III. Left ventricular anterior wall was hypokinesis.

Relevant catheterization findings:
Coronary artery angiography showed stenotic lesion with spontaneous coronary artery dissection (SCAD) in the left circumflex artery (LCx) and thrombotic lesion in the distal site.
[Interventional Management]
Procedural step::
Approached from right radial artery and used Lancher EBU3.5 guiding catheter of 6 French. Got left coronary artery, first angiography showed augmented SCAD and extinction of thrombotic lesion. Crossed Runthrough NS Extra Floppy as a guiding wire to LCx, and performed optical coherence tomography (OCT). In spite of thrombectomy, we could not found thrombus. Implanted everolimus eluting stent directly but dissection remained. Performed OCT again and succeeded in observation of the unique image about SCAD.